

907 KAR 1:170. Reimbursement for home and community based waiver services version 1.

RELATES TO: 42 C.F.R. 441 Subparts B, G, 42 U.S.C. 1396a, 1396b, 1396d, 1396n

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, is required to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Medicaid Program reimbursement provisions and requirements regarding home and community based waiver services version 1.

Section 1. Definitions. (1) "ADHC" means adult day health care.

(2) "ADHC center" means an adult day health care center that is:

(a) Licensed in accordance with 902 KAR 20:066; and (b) Certified for Medicaid participation by the department.

(3) "Cost report" means the Home Health and Home and Community Based Cost Report and the Home Health and Home and Community Based Cost Report Instructions.

(4) "DD" means developmentally disabled.

(5) "Department" means the Department for Medicaid Services or its designee.

(6) "Fixed upper payment limit" means the maximum amount the department shall reimburse for a unit of service.

(7) "HCB" means home and community based waiver.

(8) "Level I reimbursement" means a reimbursement rate paid to an ADHC center for a basic unit of service provided by the ADHC center to a participant.

(9) "Level II reimbursement" means a reimbursement rate paid to an ADHC center for a basic unit of service provided by the ADHC center to a participant, if the ADHC center meets the criteria established in Sections 5 and 6 of this administrative regulation.

(10) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(11) "Occupational therapist" is defined by KRS 319A.010(3).

(12) "Occupational therapy assistant" is defined by KRS 319A.010(4).

(13) "Participant" means a recipient who meets the:

(a) Nursing facility level of care criteria established in 907 KAR 1:022; and

(b) Eligibility criteria for HCB services established in 907 KAR 1:160, Section 4.

(14) "Physical therapist" is defined by KRS 327.010(2).

(15) "Physical therapist assistant" means a skilled health care worker who:

(a) Is certified by the Kentucky Board of Physical Therapy; and

(b) Performs physical therapy and related duties as assigned by the supervising physical therapist.

(16) "Quality improvement organization" or "QIO" is defined in 42 C.F.R. 475.101.

(17) "Speech-language pathologist" is defined by KRS 334A.020(3).

Section 2. HCB Service Reimbursement. (1)(a) Except as provided in Section 3, 4, or 5 of this administrative regulation, the department shall reimburse for a home and community based waiver service provided in accordance with 907 KAR 1:160 at the lesser of;

1. Billed charges; or

2. The fixed upper payment limit for each unit of service.

(b) The unit amounts, fixed upper payment limits, and other limits established in the follow-

ing table shall apply:

Home and Community Based Waiver Service	Fixed Upper Payment Limit	Unit of Service
Assessment	\$100.00	Entire assessment process
Reassessment	\$100.00	Entire reassessment process
Case Management	\$15.00	15 minutes
Home-making	\$13.00	30 minutes
Personal Care	\$15.00	30 minutes
Attendant Care	\$11.50	1 hour (not to exceed 45 hours per week)
Respite	\$2,000 per 6 months (January 1 through June 30 and July 1 through December 31, not to exceed \$4,000 per calendar year)	1 hour
Minor Home Adaptation	\$500 per calendar year	

(2) A service listed in subsection (1) of this section shall not be subject to cost settlement by the department unless provided by a local health department.

(3) A homemaking service shall be limited to no more than four (4) units per week per participant.

Section 3. Local Health Department HCB Service Reimbursement. (1) The department shall reimburse a local health department for HCB services:

- (a) Pursuant to Section 2 of this administrative regulation; and
- (b) Equivalent to the local health department's HCB services cost for a fiscal year.

(2) A local health department shall submit a cost report to the department at fiscal year's

end.

(3) The department shall determine, based on a local health department's most recently submitted annual cost report, the local health department's estimated costs of providing HCB services by multiplying the cost per unit by the number of units provided during the period.

(4) If a local health department's HCB service reimbursement for a fiscal year is less than its cost, the department shall make supplemental payment to the local health department equal to the difference between:

(a) Payments received for HCB services provided during a fiscal year; and

(b) The estimated cost of providing HCB services during the same time period.

(5) If a local health department's HCB service cost as estimated from its most recently submitted annual cost report is less than the payments received pursuant to Section 2 of this administrative regulation, the department shall recoup any excess payments.

(6) The department shall audit a local health department's cost report if it determines an audit is necessary.

Section 4. Reimbursement for an ADHC Service. (1) Reimbursement for an ADHC service shall:

(a) Be made:

1. Directly to an ADHC center; and

2. For a service only if the service was provided on site and during an ADHC center's posted hours of operation;

(b) If made to an ADHC center for a service not provided during the center's posted hours of operation, be recouped by the department; and

(c) Be limited to 120 units per calendar week at each participant's initial review or recertification.

(2) Level I reimbursement shall be the lesser of;

(a) The provider's usual and customary charges; or

(b) Two (2) dollars and fifty-seven (57) cents per unit of service.

(3) Level II reimbursement shall be the lesser of:

(a) The provider's usual and customary charges; or

(b) Three (3) dollars and twelve (12) cents per unit of service.

(4) The department shall not reimburse an ADHC center for more than twenty-four (24) basic units of service per day per participant.

(5) An ADHC basic daily service shall:

(a) Constitute care for one (1) participant; and

(b) Not exceed twenty-four (24) units per day.

(6) One (1) unit of ADHC basic daily service shall equal fifteen (15) minutes.

(7) An ADHC center may request a Level II reimbursement rate for a participant if the ADHC center meets the following criteria:

(a) The ADHC center has an average daily census limited to individuals designated as:

1. Participants;

2. Private pay; or

3. Covered by insurance; and

(b) The ADHC center meets the requirements established in Section 5(2) of this administrative regulation.

(8) If an ADHC center does not meet the Level II reimbursement requirements established in Section 5 of this administrative regulation, the ADHC center shall be reimbursed at a Level I reimbursement rate for the quarter for which the ADHC center requested Level II reimbursement.

(9) To qualify for Level II reimbursement, an ADHC center that was not a Medicaid provider before July 1, 2000 shall:

(a) Have an average daily census of at least twenty (20) individuals who meet the criteria established in subsection (7)(a) of this section; and

(b) Have a minimum of eighty (80) percent of its individuals meet the description of DD as established in Section 5(2) of this administrative regulation.

(10) To qualify for reimbursement as an ancillary therapy, a service shall be:

(a) Medically necessary;

(b) Ordered by a physician, a physician assistant, or an advanced practice registered nurse; and

(c) Limited to:

1. Physical therapy provided by a physical therapist or physical therapist assistant;

2. Occupational therapy provided by an occupational therapist or occupational therapy assistant; or

3. Speech therapy provided by a speech-language pathologist.

(11) Ancillary therapy service reimbursement shall be:

(a) Per participant per encounter; and

(b) The usual and customary charges not to exceed the Medicaid upper limit of seventy-five (75) dollars per encounter per participant.

(12) A respite service shall:

(a) Be provided on site in an ADHC center; and

(b) Be provided pursuant to 907 KAR 1:160.

(13) One (1) respite service unit shall equal one (1) hour to one (1) hour and fifty-nine (59) minutes.

(14) The length of time a participant receives a respite service shall be documented.

(15) A covered respite service shall be reimbursed as established in Section 2 of this administrative regulation.

Section 5. Criteria for DD ADHC Level II Reimbursement. To qualify for DD ADHC Level II reimbursement:

(1) An ADHC center shall meet the requirements established in Section 4 of this administrative regulation; and

(2) Eighty (80) percent of its ADHC service individuals shall have:

(a) A substantial disability that shall have manifested itself before the individual reaches twenty-two (22) years of age;

(b) A disability that is attributable to an intellectual disability or a related condition, which shall include:

1. Cerebral palsy;

2. Epilepsy;

3. Autism; or

4. A neurological condition that results in impairment of general intellectual functioning or adaptive behavior, such as an intellectual disability, which significantly limits the individual in two (2) or more of the following skill areas:

a. Communication;

b. Self-care;

c. Home-living;

d. Social skills;

e. Community use;

f. Self direction;

- g. Health and safety;
- h. Functional academics;
- i. Leisure; or
- j. Work; and

(c) An adaptive behavior limitation similar to that of a person with an intellectual disability, including:

1. A limitation that directly results from or is significantly influenced by substantial cognitive deficits; and
2. A limitation that is not attributable to only a physical or sensory impairment or mental illness.

Section 6. The Assessment Process for ADHC Level II Reimbursement.

(1)(a) To apply for Level II reimbursement, an ADHC center shall contact the QIO on the first of the third month of the current calendar quarter.

(b) If the first of the month is on a weekend or holiday, the ADHC center shall contact the QIO the next business day.

(2) The QIO shall be responsible for randomly determining the date each quarter for conducting a Level II reimbursement assessment of an ADHC center.

(3) In order for an ADHC center to receive Level II reimbursement:

(a) The ADHC center shall:

1. Document on a MAP-1021, ADHC Payment Determination Form that it meets the Level II reimbursement criteria established in Section 5 of this administrative regulation;

2. Submit the completed MAP-1021, ADHC Payment Determination Form to the QIO via facsimile or mail no later than ten (10) working days prior to the end of the current calendar quarter in order to be approved for Level II reimbursement for the following calendar quarter; and

3. Attach to the MAP-1021, ADHC Payment Determination Form a completed and signed copy of the Adult Day Health Care Attending Physician Statement for each individual listed on the MAP-1021, ADHC Payment Determination Form;

(b) The QIO shall review the MAP-1021, ADHC Payment Determination Form submitted by the ADHC center and determine if the ADHC center qualifies for Level II reimbursement; and

(c) The department shall review a sample of the ADHC center's Level II assessments and validate the QIO's determination.

(4) If the department invalidates an ADHC center Level II reimbursement assessment, the department shall:

(a) Reduce the ADHC center's current rate to the Level I rate; and

(b) Recoup any overpayment made to the ADHC center.

(5) If an ADHC center disagrees with an invalidation of a Level II reimbursement determination, the ADHC center may appeal in accordance with 907 KAR 1:671, Sections 8 and 9.

Section 7. Applicability and Transition to Version 2. (1) The provisions and requirements established in this administrative regulation shall:

(a) Apply to HCB waiver services provided to a participant pursuant to 907 KAR 1:160; and

(b) Not apply to individuals receiving HCB waiver services version 2 pursuant to 907 KAR 7:010.

(2)(a) The provisions and requirements established in this administrative regulation shall become null and void at the time that the next level-of-care determination has been performed regarding each participant currently receiving services via this administrative regulation.

(b) Next level-of-care determinations shall occur in accordance with 907 KAR 7:010, Section

4(2).

Section 8. Appeal Rights. An HCB service provider may appeal a department decision as to the application of this administrative regulation as it impacts the provider's reimbursement in accordance with 907 KAR 1:671, Sections 8 and 9.

Section 9. Incorporation by Reference. (1) The following material is incorporated by reference:

- (a) "Map-1021, ADHC Payment Determination Form", August 2000;
- (b) "Adult Day Health Care Attending Physician Statement", August 2000;
- (c) "The Home Health and Home and Community Based Cost Report", November 2007; and
- (d) "The Home Health and Home and Community Based Cost Report Instructions", November 2007.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at:

(a) The Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.; or

(b) Online at <http://www.chfs.ky.gov/dms/incorporated.htm>. (9 Ky.R. 1182; eff. 5-4-1983; Recodified from 904 KAR 1:170, 5-2-1986; 13 Ky.R. 1515; eff. 3-6-1987; 15 Ky.R. 689; eff. 9-21-1988; 16 Ky.R. 2606; eff. 6-27-1990; 24 Ky.R. 782; 1103; eff. 11-14-1997; 27 Ky.R. 1626, 2175; eff. 2-1-2001; 29 Ky.R. 1136, 1653; eff. 12-18-2002; 30 Ky.R. 460; 883; eff. 10-31-2003; 33 Ky.R. 597; 1326; eff. 12-1-2006; 34 Ky.R. 442; 1036; 1465; eff. 1-4-2008; 35 Ky.R. 1923; 2310; eff. 6-5-2009; TAm 7-16-2013; 42 Ky.R. 1664; 2385; 2487; eff. 4-1-2016.)